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ONE HUNDRED FIFTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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MEMORANDUM

January 30, 2017

To: Democratic Members of the Subcommittee on Health

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Strengthening Medicaid and Prioritizing the Most Vulnerable"

On **Wednesday, February 1, 2017, at 10:00 a.m. in 2123 Rayburn House Office Building**, the Subcommittee on Health will hold a legislation hearing entitled, "Strengthening Medicaid and Prioritizing the Most Vulnerable" to examine three discussion drafts including: the "Prioritizing the Most Vulnerable Over Lottery Winners Act"; "Close Annuity Loopholes in Medicaid Act"; and the "Verify Eligibility Coverage Act." Prior versions of the "Prioritizing the Most Vulnerable Over Lottery Winners Act" and the "Close Annuity Loopholes in Medicaid Act" were considered by the subcommittee in September, 2015. For more information on those bills, please find the committee memo here.

I. BACKGROUND

Medicaid is a joint federal and state program for low-income and disabled individuals. In FY 2015, Medicaid's estimated expenditures were $529 billion.[1] Historically, Medicaid eligibility has been limited to certain low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities. As of October 2016, the program had roughly 74 million beneficiaries.[2] The Congressional Budget Office (CBO) estimates that in any given month during 2016, Medicaid served 34 million children, 27 million adults (mostly in low-income working families), 6 million seniors, and 9 million persons with

[1] Government Accountability Office (GAO), *Medicaid Program Integrity: Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers* (Apr. 22, 2016) (GAO-16-402).

[2] Department of Health and Human Services (HHS), *Impacts of the Affordable Care Act's Medicaid Expansion on Insurance Coverage and Access to Care* (Jan. 18, 2017) (www.aspe.hhs.gov/sites/default/files/pdf/255516/medicaidexpansion.pdf).

disabilities.[3,4] The Affordable Care Act (ACA) also included a number of provisions that streamlined Medicaid eligibility, modernized data collection, incentivized prevention, improved program integrity, and promoted new models of delivery system reform for the most vulnerable of Medicaid beneficiaries.[5]

The ACA provided for improved access to affordable, comprehensive health insurance coverage by expanding Medicaid eligibility to childless adults. Under the ACA, states have the option to extend Medicaid coverage to most nonelderly, low-income individuals, including childless adults, who are at or below 138 percent of the federal poverty level (FPL). Studies show that low-income individuals have gained greater access to healthcare as a result of the Medicaid expansion. Individuals in Medicaid expansion states have experienced better access to primary care, increased rates of screening and diagnosis of chronic conditions, and expanded access to prescription medication.

Thirty-one states and the District of Columbia have opted to expand Medicaid.[6] The ACA's Medicaid expansion filled a major healthcare gap for low-income adults. An estimated 12 million adults under 65 have gained coverage through the Medicaid expansion.[7] The new Medicaid coverage, combined with other coverage expansions in the ACA, drove the uninsured rate in 2016 to 8.6 percent – the lowest in our nation's history.[8]

Under the ACA, the number of low-income adults who reported difficulty paying medical bills has fallen by more than 10 percent. Medicaid expansion is associated with a 20 percent reduction among adults foregoing mental health services due to cost.[9] Expansion of

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[3] Congressional Budget Office (CBO), *Detail of Spending and Enrollment for Medicaid for CBO's January 2017 Baseline* (Jan. 2017).

[4] A comprehensive policy primer on the Medicaid program is available at (http://www.cbpp.org/research/health/policy-basics-introduction-to-medicaid).

[5] A full list of the Medicaid provisions in the Affordable Care Act is available at (https://www.medicaid.gov/affordable-care-act/index.html).

[6] *Id*.

[7] CBO, *Federal Subsidies Under the Affordable Care Act for Health Insurance Coverage Related to the Expansion of Medicaid and Nongroup Health Insurance: Tables from CBO's January 2017 Baseline* (Jan. 2017).

[8] Centers for Disease Control and Prevention, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2016* (Sept. 2016).

[9] HHS, *Impacts of the Affordable Care Act's Medicaid Expansion on Insurance Coverage and Access to Care* (Jan. 18, 2017).

Medicaid has further lowered uncompensated care costs by $10 billion between 2013 and 2015,[10] and has improved beneficiaries' abilities to afford care.

Medicaid coverage has been the main driver of Medicaid spending growth over the last two decades. Enrollment growth accounted for nearly four-fifths of Medicaid's spending increase over this period.[11] Roughly half of Medicaid enrollment growth between 2000 and 2013, was among children, catalyzing the dramatic reduction in the child uninsured rate from 12.3 percent in 2000, to 4.5 percent in 2013.[12] Most of the Medicaid enrollment growth since 2013 has been among adults eligible for Medicaid under the ACA's coverage expansion, reducing the uninsured rate for non-elderly adults from 20.4 percent in 2013 to 12.8 percent in 2015.[13] In the Centers for Medicare and Medicaid Services' latest actuarial report, state spending per person on adults who are newly eligible for Medicaid under the ACA fell by 6.9 percent in 2016, and will keep falling in future years.[14]

Over the past 30 years, Medicaid costs per beneficiary have essentially tracked costs in the health care system as a whole, public and private.[15] Moreover, Medicaid has controlled per enrollee costs better than other payers. The per enrollee cost of Medicaid coverage grew 1.9 percent annually between 2000 and 2014, compared to 5.9 percent growth in private coverage and 5.1 percent in Medicare.[16] After accounting for the greater health needs of Medicaid

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[10] White House Council of Economic Advisers, *The Economic Record of the Obama Administration: Reforming the Health Care System* (Dec. 2016) (www.obamawhitehouse.archives.gov/sites/default/files/page/files/20161213_cea_record_healh_care_reform.pdf).

[11] Centers for Medicare and Medicaid Services (CMS), *National Health Expenditure Accounts* (2015) (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html).

[12] Centers for Disease Control and Prevention, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2016* (Sept. 2016).

[13] *Id.*

[14] HHS, *2016 Actuarial Report on the Financial Outlook for Medicaid* (Jan. 2017) (https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf).

[15] Center on Budget and Policy Priorities (CBPP), *Frequently Asked Questions About Medicaid* (Aug. 2016) (http://www.cbpp.org/research/health/frequently-asked-questions-about-medicaid).

[16] CMS, *National Health Expenditure Accounts* (2015) (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html).

enrollees, it costs 20 percent less to cover someone in Medicaid than if they were enrolled in private insurance coverage.[17]

II. DISCUSSION DRAFT OF H.R. ___, THE PRIORITIZING THE MOST VULNERABLE OVER LOTTERY WINNERS ACT

A lump sum payment is counted in Medicaid as income in the month in which it is received, and is not considered as an asset thereafter (with the exception of those Medicaid beneficiaries who remain subject to an asset test, such as most elderly and disabled beneficiaries). The lump-sum income that is taxable is now included in a tax-filer's annual income level; States re-determine Medicaid eligibility on an annual basis.[18] This calculation aligns with the ACA's streamlined approach to determine eligibility for Medicaid and Children's Health Insurance Program (CHIP) in addition to premium tax credits (PTCs) and cost-sharing subsidies (CSRs), which help individuals afford coverage. Prior to the ACA, states had widely varying rules regarding what income and assets were "countable" for purposes of eligibility for Medicaid, and what was not countable income ("disregards").

The draft legislation would require states to count "lump sum income" that an individual receives as though it were income that the individual is receiving for anywhere from two months to ten years, depending on the amount of the income received. The threshold amounts have increased from last Congress to $80,000 and up, and the draft legislation now includes a hardship exemption. The draft would also direct savings resulting from this policy to a Medicaid Improvement Fund (MIF). A small proportion of the funds would go towards oversight of Medicaid contracts and demonstration projects, with the remainder earmarked for states that have a waiting list for home and community-based services (HCBS).

III. DISCUSSION DRAFT OF H.R. ___, CLOSE ANNUITY LOOPHOLES IN MEDICAID ACT

Annuities are used as a vehicle for protecting community spouse assets while still qualifying for Medicaid coverage of long term services and supports (LTSS), particularly for couples in which one spouse remained in the community. By purchasing a single premium annuity, couples convert assets to an immediate income stream for the community spouse. Since Medicaid does not count a community spouse's income (within state-specific limits) in determining the institutionalized spouse's Medicaid eligibility, a couple can conserve more of their resources for the community spouse.by converting assets to income via an annuity.

The draft requires that half of the income produced by Medicaid-compliant annuities be considered available to the institutionalized spouse. This treats the income produced from

[17] The Henry J. Kaiser Family Foundation (KFF), *What Difference Does Medicaid Make?* (May 2013) (https://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf).

[18] *See* "Periodic Redeterminations of Medicaid Eligibility" §435.916.

annuities more like combined resources, rather than as income solely for the community spouse. This would apply to an annuity created in the 60-month "lookback" period. The draft also includes the MIF provision described above.

IV. DISCUSSION DRAFT OF H.R. ___, VERIFY ELIGIBILITY COVERAGE ACT

Medicaid-eligible individuals must be U.S. citizens or have an eligible immigration status. Moreover, their citizenship or immigration status must be verified. When completing applications, U.S. citizens attest under penalty of perjury that they are citizens. In practical terms, the vast majority of Medicaid applicants provide their Social Security number (SSN) and it is used along with other personal information to complete a data match with Social Security Administration (SSA) records to verify U.S. citizenship. The majority of applicants are successfully verified using this process. In some instances, however, individuals must send in paper documentation to verify that they are U.S. citizens. If applicants have satisfied all other eligibility requirements—except for verification of citizenship—then the Medicaid agency will provide Medicaid coverage to the applicant during a state-defined time period that is referred to as a reasonable opportunity period (ROP). States set a timeframe in which consumers can submit their documents and for workers to review the documents to verify citizenship. During this time, states receive the federal matching portion of reimbursement for Medicaid coverage provided during the ROP.

The draft legislation removes federal financial participation (the federal portion of the Medicaid matching payment) from states during the ROP for those individuals having a citizenship status that is not immediately verifiable. It also includes the above-described MIF provisions.

V. HOME AND COMMUNITY BASED SERVICES (HCBS)

All three drafts under consideration include directing the savings of the policy toward Home and Community Based Services (HCBS) waiting lists operated by some states. Aside from home health services for people who are eligible for nursing facility services, Medicaid HCBS are provided at state option. States can choose the specific services and populations they wish to target as well as how many people to serve under Section 1915(c) waivers. In recent years, some states also have used Section 1115 waivers to provide Medicaid HCBS comparable to what is available under Section 1915(c). There also are a variety of Medicaid state plan authorities from which states can choose to offer HCBS, including the Section 1915(i) HCBS state plan option, Community First Choice attendant care services and supports, personal care, private duty nursing, and others.

HCBS waiver waiting lists result from states' ability to cap enrollment under Section 1915(c) waivers; this is a state flexibility. There is no empirical or causal relationship between a state's decision to operate a waiting list for HCBS services, and the level of coverage or benefits provided in other parts of the program.

VI. WITNESSES

John McCarthy
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Avik Roy
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Judith Solomon
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